

**Individual's Name:** \_\_\_\_\_  
**He-M 12.01.04; 12.0.05; 1201.07; 1201.08; 1201.09 - NH LICENSED NURSE QUALITY REVIEW**

He-M 1001   He-M 507   He-M 518   He-M 521   He-M 524   He-M 525

<b>Compliance with He-M 1201.04</b>	
Individuals initially assessed to determine level of support for med administration:	Y <input type="checkbox"/> N <input type="checkbox"/>
Guardian consent to administer meds present	Y <input type="checkbox"/> N <input type="checkbox"/>
Current med authorization for provider	Y <input type="checkbox"/> N <input type="checkbox"/>
Medication orders for prescription, OTC, and PRNs present for all meds in record	Y <input type="checkbox"/> N <input type="checkbox"/>
PRN protocols with specific written parameters signed by NT or prescriber present	Y <input type="checkbox"/> N <input type="checkbox"/>
Med error documentation	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Compliance with He-M 1201.05</b>	
Self-administer medication assessment completed and current	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Compliance with He-M 1201.06</b>	
Provider notifies the NT of any change in medication orders	Y <input type="checkbox"/> N <input type="checkbox"/>
Provider notifies NT when clarification of orders or administration is needed	Y <input type="checkbox"/> N <input type="checkbox"/>
Provider notifies NT whenever individual is hospitalized or receives medical treatment	Y <input type="checkbox"/> N <input type="checkbox"/>
Provider notifies NT if a new individual begins to receive services	Y <input type="checkbox"/> N <input type="checkbox"/>
Provider maintains documentation of current medication administration authorization	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Compliance with He-M 1201.07</b>	
Documentation of med logs performed by authorized or licensed persons only	Y <input type="checkbox"/> N <input type="checkbox"/>
Med administration documentation done in timely manner	Y <input type="checkbox"/> N <input type="checkbox"/>
Cover sheet with full signatures and initials of all authorized providers/licensed persons who administer	Y <input type="checkbox"/> N <input type="checkbox"/>
Controlled drug inventory present, current, and accurate	Y <input type="checkbox"/> N <input type="checkbox"/>
Labels/Orders/Logs match	Y <input type="checkbox"/> N <input type="checkbox"/>
Documentation is complete and legible	Y <input type="checkbox"/> N <input type="checkbox"/>
Drug info sheets present	Y <input type="checkbox"/> N <input type="checkbox"/>
PRN entries include reason and effect	Y <input type="checkbox"/> N <input type="checkbox"/>
OTC medications have documentation regarding consult for right name/dose/route	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Compliance with He-M 1201.08</b>	
Medications stored in locked container or NT documentation present	Y <input type="checkbox"/> N <input type="checkbox"/>
Controlled medications are double-locked	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Compliance with He-M 1201.09</b>	
QA performed at least semi-annually for family residences	Y <input type="checkbox"/> N <input type="checkbox"/>
QA performed at least monthly for first 3 months of individual new to services or in new settings	Y <input type="checkbox"/> N <input type="checkbox"/>
QA performed at NT determined frequency in combined day/res	Y <input type="checkbox"/> N <input type="checkbox"/>
QA performed monthly in all other settings	Y <input type="checkbox"/> N <input type="checkbox"/>

**Issues addressed from last QA (if needed):**

**Actions Needed:**

Person responsible for action signature:

Timeframe:

RN signature:

Date:

Program Manager signature:

Date: